Prescribed Drugs

Definition: Prescribed Drugs are part of the MR/RD Waiver as an extended State Plan service. That means that prescribed drugs are covered for all Medicaid recipients through the State Plan, but there are limits to the coverage. The MR/RD Waiver allows an additional two (2) prescribed drugs over the State Plan limit.

The State Plan covers **all** prescribed drugs for Medicaid recipients under age 21 (coverage is in effect through the month of their 21st birthday) and covers four (4) prescribed drugs per month for those over age 21 who are not enrolled in the MR/RD Waiver.

The MR/RD Waiver covers two (2) additional prescriptions per month for those over age 21 and enrolled in the Waiver.

Effective July 2, 2001, the State Plan will reimburse for a maximum one-month supply of medication per prescription or refill (34-day supply). Therefore, staggering of medications with a 90-day supply is no longer allowed.

Please note: there is an exception to this policy. Pharmacists can submit the prescription limit override code if: (1) the monthly prescription limit has been met, (2) the recipient has one of the following conditions, and (3) the prescription is for an essential drug used in the patient's treatment for one of the following conditions:

- Acute Sickle Cell Disease
- Behavior Health Disorder
- Cancer
- Cardiac Disease
- Diabetes
- End stage lung disease
- End stage renal disease
- HIV/AIDS
- Hypertension
- Life-threatening illness
- Organ Transplant
- Terminal stage of an illness

The override of the monthly prescription limit is reserved for only those prescriptions that, in the clinical judgement of the pharmacist, meet the prescription limit override criteria. Pharmacists must not use the override code for a prescription until after the monthly prescription limit has been reached.

NOTE: Not all drugs prescribed by a physician will be covered. Drugs such as those used for weight control, fertility, smoking cessation, etc. may not be covered.

Providers: Prescribed drugs are provided by licensed pharmacies that are enrolled with the SC Department of Health and Human Services.

Arranging for the Services: Once it is determined that prescribed drugs are needed, the recipient or his/her family should be provided with a listing of enrolled providers of prescribed drugs. You should assist as needed in selecting a convenient provider.

The need for the prescribed drugs must be clearly identified in the recipient's plan including the amount and frequency of the service and the provider.

Please note that in some circumstances the individual/legal/guardian/residential staff will not notify the Service Coordinator that an individual needs prescribed drug services. They will simply present their Medicaid Card to their provider when they need additional prescribed drugs. In order to ensure that the Single Plan supports these services (as mandated by the MR/RD Waiver document and HCFA Protocol), you should plan for these services when completing the Single Plan (the Service Coordinator should already be including an "anticipated state plan services statement" in the plan). The Service Coordinator should include a statement in the plan stating, for example, "Bobby may receive prescribed drugs through the MR/RD Waiver during the upcoming year."

For prescribed drugs, one unit equals one medication/drug. Once the anticipated units are determined, the units must be entered into the Waiver Tracking System (S23).

The recipient must present his/her Medicaid card to the enrolled pharmacy as authorization for payment.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service. The following criteria should be followed when monitoring Prescribed Drug Services.

- At least monthly for the first two months
- At least quarterly thereafter

Monitorship of Prescribed Drugs may take place during contact with the individual/family or pharmacists. It must always include a review of the individual's current health status. Some items to consider during monitorship include:

→ Are the prescribed drugs listed on the Single Plan correctly? If not, what are the deletions or additions?
→ If a medication is deleted, why is the individual no longer taking the medication?
→ If a medication is added, who prescribed the medication? Why was the medication prescribed? Is it for an acute condition or is the individual expected to take the medication long term?
→ Is the individual using a particular provider for prescribed drugs?
→ Are they satisfied with the pharmacy?

- → Is the individual receiving all of the prescribed drugs that have been ordered by his/her physician(s)? If not, why not?
- → Is payment of medications beyond the 6 allowed through the Waiver a concern/need?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.